

**Kentucky Board of Medical Licensure
Change of Address Notice**

Fax: 502/429-7158

(Please Print or Type)

Date:_____ KY License #:_____

Name:_____
(last) (first) (m.i.)

Mailing Address:_____
(Street)

(City) (State) (zip)

Practice Address:_____
(Street)

(City) (State) (zip)

Office Telephone:()_____ KY County:_____

**Kentucky Board of Medical Licensure
310 Whittington Parkway, Ste. 1B
Louisville, KY 40222**